**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

VALLEY REGIONAL MEDICAL CENTER
c/o HOLLOWAY & GUMBERT
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3916

**Respondent Name**
BROWNSVILLE ISD

**Carrier's Austin Representative Box**
Box Number 29

**MFDR Tracking Number**
M4-05-2121-01

**MFDR Date Received**
November 19, 2004

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "It is our position that reimbursement was improperly determined pursuant to the acute care inpatient hospital fee guidelines of the Texas Workers' Compensation Commission . . . The carrier improperly priced this claim using the per-diem reimbursement methodology . . . which is inapplicable to claims with ICD-9 primary diagnosis codes as listed in Rule 134.401(c)(5). . . . the hospital contends the charges for its services are fair and reasonable as based on several factors. Fees for goods and services provided by Valley Regional Medical Center are based upon the rates that the market will bear in the geographic locale of the hospital. . . . the prices, which the hospital must charge for its goods and services are affected by, market forces beyond its control, including but not limited to the costs for raw materials, labor, and transportation of goods and supplies. . . . Fees are set based upon the cost factors described above, as well as the cost of maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel. . . . The hospital's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area"

**Amount in Dispute:** $15,979.36

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "F&R paid."

**Response Submitted by:** Dean G. Pappas & Assoc. for Tristar/BISD, PO Box 66655, Austin, Texas 78766

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 21, 2003 to November 23, 2003 | Inpatient Services | $15,979.36 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on November 19, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 23, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 0037 – EXCEEDS CONRACT PARAMETER(S).

**Findings**

1. The insurance carrier reduced or denied disputed services with reason code 0037 – "EXCEEDS CONRACT PARAMETER(S)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 844.8. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. 28 Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Fees for goods and services provided by Valley Regional Medical Center are based upon the rates that the market will bear in the geographic locale of the hospital."
   - The requestor did not discuss or submit documentation to support what rates the market will bear in the geographic locale of the hospital.
   - The requestor's position statement asserts that "the prices, which the hospital must charge for its goods and services are affected by, market forces beyond its control, including but not limited to the costs for raw materials, labor, and transportation of goods and supplies."
   - The requestor did not discuss or submit documentation to support what its costs are for raw materials, labor, or transportation of goods and supplies.
   - The requestor's position statement asserts that "Fees are set based upon the cost factors described above, as well as the cost of maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel."
   - The requestor did not discuss or submit documentation to support what its costs are for maintaining the physical plant of the hospital, including highly trained nursing and administrative personnel.
   - The Division has previously found that a reimbursement methodology based on hospital costs does not

produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 that:

> "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models… are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs… Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."

Therefore, a reimbursement amount that is calculated based upon a hospital's costs cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor's position statement asserts that "The hospital's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area."
- No documentation was submitted to support that the hospital's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area.
- The requestor's position statement asserts that "the hospital contends the charges for its services are fair and reasonable as based on several factors."
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, payment for the full amount of the requestor's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | Grayson Richardson | December 19, 2012 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.